РАБОЧИЙ ПРОЕКТ НОМЕР CAR-KAZ-1
TECHNICAL NOTE NO. CAR-KAZ-1

Оплата за медицинские услуги в Южно-Казахстанской области
User Chargers in South Kazakhstan Oblast

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User Charges in South Kazakhstan Oblast

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INTRODUCTION/BACKGROUND

In 1993, health services providers in South Kazakhstan Oblast (SKO) had a positive experience with a variety of self-financing initiatives, including user charges. In 1994 many of the elements of the self-financing program were ruled to be not in conformity with the national Constitution, so they were stopped or severely curtailed. However, there is some ambiguity about what the Constitution says on the matter. It can be read as to delegate the authority to make such decisions to the basic health law of the nation. This law permits user charges.

Beside the issue of constitutionality, the positive experience of the providers in 1993 largely conformed to what has been found worldwide. Moreover, the overall economic situation and the situation of financing for the health sector has worsened. The implementation of a mandatory health insurance (MHI) program in SKO in 1995 may address some of the health sector's financing problems, but self-financing initiatives can be a useful complement. Finding a way to resume the self-financing program would seem to be in order.

Generally, the motivation for reforms in the financing and organization of health services is dissatisfaction with one or more of the following:

- Quality of services offered
- Quantity of services available
- Access to services by all population groups

In SKO the quality and quantity of services offered by the health system are problematic and are becoming more so, given the scarcity of budgetary support. Drugs, supplies, and facility and equipment maintenance are difficult to ensure. The productivity of health services personnel is low and may worsen as the real value of salaries decreases. Since nearly all health services are offered to all at no charge, access is not now a major issue. However, the growing scarcity of drugs and supplies in provider facilities means that consumers must purchase them on their own. Leaks have developed in the social safety net that has protected disadvantaged groups like pensioners, veterans, the disabled, women, and children. This combination decreases the likelihood that disadvantaged groups can be sure to receive complete health services.

Thus, it is important for the SKO Department of Health (DOH) to find a reform strategy that increases the amount of resources for health, ensures that those resources are used efficiently, and protects the interests of the disadvantaged. The MHI program, to be implemented in SKO ahead of the rest of Kazakhstan in 1995, can be expected to move toward the achievement of these objectives. However, a user-charges program could be a useful complement to the MHI program.

This paper begins by explaining what is meant by user charges. Then it describes the methods used to gather data from several facilities in Shymkent and Almaty and where comparative information

from worldwide experience was found. It then summarizes what was found, compares the findings with worldwide experience, and makes recommendations.

WHAT IS MEANT BY USER CHARGES

A user charge program asks *some* users of *some* services to pay *something* for them. Defined disadvantaged population groups may be exempted from payment on the grounds that they would be unable to pay without hardship. Some services may be offered free of charge if they are likely to be under-used if they would bear a charge. Prices charged by governments often are less than or equal to the cost of providing the services.

Since MHI is to be implemented on a pilot basis in SKO, it is useful to consider how user charges may be employed in conjunction with insurance. User charges may be a complement to insurance programs, like MHI, in the form of co-payments and deductibles. Co-payments involve a sharing of payments for services between the user and MHI, where the bulk of the charges for the services would be covered by MHI. A deductible system requires users of services to pay charges up to a given threshold in a period of time (usually one year), before MHI pays additional charges.

METHODS

This report is based on worldwide experience with user charges for health services (Makinen and Raney 1994) and information gathered in Shymkent and Almaty from health services providers (see Box 1) and government health authorities. In Shymkent, interviews were conducted with managers of six facilities and SKO Department of Health authorities. In Almaty, interviews were conducted with the Ministry of Health (MOH), Almaty City health authorities, and the manager of the self-financing department of Almaty City Hospital Number 1. The interviews with facility managers focused on "self-financing" programs. These programs earned revenues supplementary to government budget allocations for the providers through contracts with enterprises, insurance payments, or direct payments for services by consumers. The interviews asked for descriptions of the programs, the proportion of total revenues generated, how prices were set, what the revenues were used for, and whether certain groups of consumers or illnesses were exempted from charges.

Facilities Interviewed

Shymkent

- Dermatology and STD Polyclinic
- Diagnostic Centre
- Emergency Hospital
- Eye Hospital
- Avtomobilist Polyclinic
- Healthy Teeth Stomatological Polyclinic

Almaty

- City Hospital Number One

Box 1

FINDINGS

Four of the six providers visited in Shymkent and Almaty City Hospital Number 1 received the bulk of their funding through government budget allocations, so they may be considered to be co-financed by user charges and the budget. The remaining two providers in Shymkent, the Avtomobilist and Healthy Teeth Polyclinics, rely entirely on user and third-party payments. The former group of providers gives paying patients access to some combination of better doctors, shorter waiting times, and other amenities in return for their money. The other two polyclinics are struggling to survive with their totally self-financed programs. The latter two are not affected by the ruling on the constitutionality of user payments, since they are no longer considered government-operated facilities.

Importance of Self-Financing Revenues. The proportion of total revenues generated by the self-financing programs in the co-financed facilities ranges from 1 to 8 percent. This is not a large proportion of total resources, but the sums available through the program were available to the provider managers for discretionary allocation. Government budgetary funds must be allocated strictly according to 18 chapters, giving managers little flexibility. Thus, the self-financing revenues were disproportionally valuable to managers.

Pricing Methods. All of the providers set prices using estimates of input costs, including items such as salaries, payroll taxes and social fund contributions, drugs, utilities, space used, and administrative overhead. Adjustments are made periodically to account for inflation. Although the pricing methodologies were not examined in depth, the basic concepts are sound. However, it is likely that some distortions may be present in the implementation of the concepts. For example, accounting rules under the Soviet Union led to undervaluation of durable equipment and capital. If these rules still are being applied, the input values assigned to use of space and equipment would be distorted. In addition, some providers may not be using all input prices in their price calculations.

Use of Self-Financing Revenues. The revenues earned through the self-financing programs in the co-financed facilities are used to provide extra pay for provider employees and to purchase additional supplies, equipment, and expansion of the facilities. The extra pay for employees is allocated on the basis of performance. Frequently the extra pay is for the employees who are the providers of the self-financed services. At the Dermatology and STD Polyclinic, the performance bonuses are paid to teams made up of doctors, nurses, and medical aides, who work together. The supplies and equipment purchased with self-financing revenues help to improve the quality of services offered. In the entirely self-finance facilities the revenues earned must be used to pay for all inputs.

Self-Financing and Equity. Most of the self-financing charges are paid by those patients who are provided services in special settings or by enterprises for their employees. All of the facilities reported that they exempt from payment disadvantaged groups, including pensioners, children

under 15, veterans, and the disabled. No charges are made for treatment of chronic illness nor communicable diseases. The Avtomobilist Polyclinic, which is struggling financially, even continues to provide services to employees of enterprises when the enterprises do not make the payments required by their contracts with the Polyclinic. The total debt to the Polyclinic from such non-payments by enterprises was 800,000 tenge ($US 1.00 = 52) tenge) in December 1994. Healthy Teeth Polyclinic used to receive special budget allocations to cover services provided to the disadvantaged, but no longer does. It still provides services to disadvantaged patients at no charge. At Healthy Teeth Polyclinic, paying patients often are offered shorter waiting time and access to the most popular doctors. However, the basic services offered to all patients are reported to be the same.

The Worldwide Experience with User Charges and the SKO Experience

Worldwide experience with user charges largely conforms with SKO's self-financing experience. The points below summarize the main findings from around the world. Each is followed by a brief summary of SKO's experience.

1. Worldwide: Many people of all social and economic levels already spend substantial amounts of money for health (drugs and herbs purchased privately, informal payments made to providers). Such spending often is ineffective and inefficient.

   SKO: In SKO there is anecdotal evidence of consumer spending on traditional medicines and of informal payments to providers to reduce waiting time and to gain access to better doctors. By March 1995 the results of the household survey conducted by the DOH should shed more light on consumer spending.

2. Worldwide: The revenues generated by user payments can be important supplements to other sources of funds (e.g., budgetary allocations or insurance payments).

   SKO: During the 1993 period of self-financing, SKO providers found that the revenues generated in the four co-financed facilities made up 1-8 percent of government budgetary allocations. These relatively small sums were found to be important by provider managers, since the revenues could be used to buy critical supplies and to offer motivation payments to staff.

3. Worldwide: User charges can signal both consumers and providers about the cost of services used and the demand for services. Further, prices of services may be set low relative to costs to encourage the use of certain services, e.g., preventive services and treatment of chronic illnesses and communicable diseases.

   SKO: SKO providers set prices as a function of the resources used to provide services. This told consumers (or those who paid in their place, usually employers) about the value of

the services they were using. No charge was made for many preventive services and treatment of chronic illnesses.

4. Worldwide: Accessibility to quality services by the poor and disadvantaged may be improved if such groups are exempted from payment, while those with higher incomes are required to pay.

   SKO: Providers in SKO generally exempted pensioners, veterans, the disabled, pregnant women, and children under 15 years of age from payment of user charges.

MODEL USER-CHARGE PROGRAM:

Worldwide experience with user charges allows a model program to be described, as is shown in Box 2. The self-financing programs of Shymkent facilities correspond to items 1, 3, 4, part of 5, and 6 of the model program.

Item 5, differential charges according to cost of services is practiced to the extent that prices are set according to calculated input prices. However, item 5 also refers to charging higher prices for higher-level referral services. Since none of the facilities visited was in a referral relationship with another self-financing facility this situation was not observed. Using correctly-valued input prices as the basis for setting charges would produce the result suggested by item 5, if it were used for referral facilities.

The planned implementation of the MHI program in 1995 in Shymkent will be a financial risk-sharing mechanism that will help protect consumers against the charges that could come with illness requiring expensive treatment (item 2).

Community oversight of the use of user-charge revenues (item 7) is not present in the Shymkent programs. Facility managers enjoy the ability to use freely the revenues generated by self-financing. A great deal of freedom to manage resources is important to preserve, since, in part, it allows items 4 and 6 of the model program to be met. However, worldwide experience indicates that some kind of oversight and accountability on the use of funds is important to ensure that the funds are not misused or diverted to personal ends. Further, this kind of oversight is needed to maintain the credibility of the programs.

Model User-Charge Program

1. **Payment of charges only is asked of those able to pay; the poor and disadvantaged are exempted.**
2. **Financial risk-sharing mechanisms (e.g., insurance) cover high-cost, unpredictable needs for services.**
3. **No or low charges are made for preventive services and the treatment of communicable diseases.**
4. **The additional resources generated from user payments are used to improve quality of services.**
5. **Charges are graduated to reflect costs of services.**
6. **Facilities earning revenues from user charges retain most (if not all) of them to replace supplies and to supplement salaries on the basis of performance.**
7. **Community boards provide oversight to the collection and use of funds by facility managers.**
8. **A portion of revenues goes to a fund to help subsidize facilities in low-income and -population density areas.**

Box 2

Different facilities may have different capabilities to earn self-financing revenues. To account for this, in successful user-charge and self-financing programs, often a portion of revenues earned is put into an "equalization" or "solidarity" fund. The funds accumulated are used to provide extra funding to facilities which serve proportionally more disadvantaged people, hence are unable to generate as many resources. Other facilities may be located in areas with low population density, so they have relatively low numbers of patients per day, even with minimum staffing, so the cost per patient is higher than elsewhere. Similar situations may arise among Shymkent facilities.

RECOMMENDATIONS

The self-financing programs of the Shymkent health facilities interviewed largely were successful in 1993. Their experience conformed to worldwide experience. They contained most, but not all, of the elements of a model user-charge program. The elements they were missing could be added. As the MHI program is implemented, user-charges in the form of co-payments or deductibles should be considered. The national MOH should seek a way to make self-financing programs clearly legal. Some specific recommendations follow:

- The national MOH should find a way to make self-financing programs for government health facilities clearly legal. The MOH may wish to allow SKO to test formally self-financing methods, along with the MHI program.

- Clear legalization of user charges should be accompanied by a framework that permits broad flexibility in the use of the revenues generated by managers, while ensuring that the managers are accountable to some kind of oversight body for the management of the funds. Audit should become a routine practice.

- The MHI program should consider co-payments and deductibles as a complement to payroll taxes and state budget contributions into the insurance fund and to insurance-fund reimbursement of providers. In the near term, while the financial health of many of Shymkent's enterprises is in question, because of the painful transition to a market economy, co-payments, deductibles, and direct charges for services may be even more important sources of additional funds than in more- normal macroeconomic times.

- Facilities should be provided with assistance in improving cost accounting and price-setting methodologies, including freeing them from accounting rules which distort actual values of inputs. No price controls should be placed on user charges.

- A clear policy about which groups should be exempted from payment should be developed. The groups already exempted by facilities is a good start toward such a policy. These groups are children under 15, pensioners, veterans, the disabled, and pregnant women. The SKO DOH may wish to pay facilities for the services provided to members of these groups in lieu of user payments. This could be done in the form of an annual capitation payment for each disadvantaged patient registering for services with a given facility for the year. Another option, used by the Family Health Center in Odessa, Ukraine, is to set up a charity fund from which payments are made on behalf of the poor and disadvantaged. The Odessa charity fund receives funds from enterprises.

- A similar policy should be developed about which illnesses (usually chronic and communicable) should be exempted from charges. Again, the SKO DOH may wish to pay facilities for providing such services in lieu of user charges.

- The SKO DOH should study whether an "equalization" or "solidarity" fund is needed to help some facilities.

- The SKO DOH should select some indicators of performance for the self-financing program to monitor revenues generated (e.g., total revenues from self-financing and percent of overall total), uses of self-financing revenues (e.g., proportions used for performance payments to personnel and for extra drugs and supplies), and effects on utilization of

services by all groups, particularly the disadvantaged (e.g., ambulatory visits per year for population samples).

REFERENCE

Makinen, M. and L. Raney, "Role and Desirability of User Charges for Health Services", Abt Associates Inc., Bethesda, MD, USA, 1995.